Promoting the Psychosocial Well Being of Children Following War and Terrorism
M.J. Friedman and A. Mikus-Kos (Eds.)
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Post-War Communities Overcoming Traumas and Losses

Matthew J. FRIEDMAN, MD, PhD
National Center for PTSD, White River Junction, Vermont,
Dartmouth Medical School, Hanover, New Hampshire

I. Scope of the Problems

It is difficult to appreciate how much communities have been destroyed or disrupted by war and other catastrophic events in recent decades. Between 1960 and 2000, the number of refugees worldwide has increased tenfold from 1.4 to 11.5 million. An additional 17–25 million were internally displaced people (IDPs) within their own countries because of armed conflict or generalized violence and an additional 30 million people were uprooted because of natural environmental or technological disasters [1].

The social consequences of traumatic stress include: cultural disintegration, erosion of the social fabric, community fragmentation, loss of social authority and institutions, ethnic discrimination and hatred, forced migration, violence against women and children, and genocide. Communities disrupted by such catastrophic events can no longer meet the basic economic, social, and cultural needs of their citizens. They can no longer provide basic needs such as: safety, security, food, shelter, protection of human rights, health services or education.

The emotional consequences to people affected by community disruption due to war, terrorism or forced migration are far-reaching. People are distressed, fearful and anxious about the loss of loved ones and homes, angry at their oppressors and full of the frustration embodied in feelings of hopelessness and helplessness. Refugees and IDPs who go into exile as a community or group and remain together in camps, can sometimes maintain ongoing family and community support, thereby retaining their cultural identity, traditions and mores. In this regard, they may fare better than people who have been unable to reconstruct some semblance of the community of origin they have lost.

Individuals, families and communities exposed to war, terrorism and forced migration have experienced or witnessed many catastrophic events including: torture, rape, abductions, sexual violation, war wounds, premature death, deprivation of basic needs, persecution and harassment, loss of home, ethnic cleansing, and genocide. No wonder that the risk of psychiatric disorder and suicide is much higher among these individuals. In order to appreciate the magnitude and duration of pain and suffering encountered it is important to recognize that traumatization is usually not a specific traumatic event but rather an enduring, cumulative, "chain of traumatic stress experiences that confront... (individuals) with utter hopelessness and interfere with his or her personal development over an extended period of time." [2]

At least half of all refugees and IDPs are children who have been deprived of many of the basic rights listed in the United Nations Convention on the Rights of the Child [3]. These include the right to remain with parents, the right to protection from all forms of physical and mental abuse and neglect, access to health care and education, protection from sexual exploitation and abuse, prevention of abduction, sale and exploitative trafficking, and other rights [4,3].

As noted by Yule and associates (2003) [3] the effects of war on children can be far-reaching. Whether or not they are directly affected by their traumatic experiences, they are indirectly affected by what they witness and by the impact of traumatic exposure on parents and caretakers. Both direct and indirect experiences have an adverse impact on children's psychological development and in a worse case scenario may be the precipitating cause of psychiatric disorders among children.

At the outset, it is important to emphasize that most adults and children exposed to extreme stress are resilient. Even after severe traumatic events, the majority of people will cope effectively and be able to move forward in their lives, once the danger is past. It is important, however, to understand that within the context of community disruption/disintegration due to war or violence, a wide spectrum of responses may occur. These vary from mild, transient distress to severe, chronic and incapacitating disability. Three domains have received most attention, in this regard; a) transient psychological distress that may progress to psychiatric disorders; b) temporary physical symptoms and discomfort that may escalate to serious medical problems; and c) temporary functional incapacity that may evolve into persistent marital, family, social, occupational, and financial problems.

It is now well recognized that exposure to traumatic stress may precipitate chronic psychiatric disorders such as depression, post-traumatic stress disorder (PTSD), alcoholism and substance abuse, and other anxiety disorders. Significant impairment in marital, social and occupational function as a result of psychiatric disability is also generally acknowledged. Less well understood is the growing evidence that PTSD and depression appear to be associated, if not causally related, to the onset and chronicity of medical disorders [5].

A meta-analysis of epidemiological research from over 160 disasters has shown that school-age youth and survivors in developing countries are at greater risk for post-disaster mental health problems than appropriate comparison groups [6,7]. Individual-level risk factors for poor mental health outcomes taken from that same meta-analysis [6] include magnitude of traumatic stress, life threat, personal and material losses, and living in a neighborhood or community that has been highly disrupted or traumatized. Other risk factors for children are: the presence of parental distress, interpersonal conflict or lack of a supportive atmosphere at home, and possessing few, weak, or deteriorating social resources.

Milgram and associates (1995) [8] have identified the following high risk groups during the psychosocial disruption occurring after a war: the elderly, children, rural residents, economically disadvantaged and poorly educated individuals, people without kin support and previously traumatized people who receive little support.

II. Assessing Community Stress

A thorough and comprehensive assessment is the key to planning an effective community intervention and for appreciating the many aspects of community function that

may be adversely affected by war, terrorism and forced migration. Figley (1995) [9] has provided an excellent template for such an assessment. Here is a slightly modified version of Figley's checklist.

Demographic profile of the stricken population
a) what is the primary affected population (racial, ethnic, religious, etc)?
b) what is the primary exposed population (victims closest to the destruction, rescue workers, etc.)?
c) what was the target population (selected victims in war/terrorism)?
d) who was made homeless because of the event?

Nature of the disaster
a) what is the magnitude of loss (deaths, number injured, material losses)?
b) what is the known or potentially unknown hazard due to the event (landmines, radiation, toxins, biological agents, etc.)?
c) what is the scope of the impact on community functioning and infrastructure (was the major destruction central, intermediate or peripheral)?
d) to what degree was escape possible during or immediately after the event?

Channels of communication
a) how much has communication (telephones, media, community sources) been disrupted?
b) how open, public, accurate and credible are the surviving channels of communication?

Authority structure
a) did political structures and agencies survive?
b) how effectively can they function?
c) are they credible and trusted by the community?

National resources
a) how available are material resources needed for recovery?
b) if they are available elsewhere, what is the likelihood that they may be efficiently transported to the disaster area?
c) how available and effective are rescue and emergency health services (e.g., military, NGOs, Red Cross, etc.)?

Social Support at the Community and Family Level
a) availability of voluntary associations and mutual support systems?
b) availability of support within the extended family or kinship system?
c) presence of family and community leadership?
d) how free is the family to act and move as it wishes (in contrast to repression by authorities)?

Attitudes towards and institutions dealing with loss and mourning
a) this factor attempts to assess the degree to which indigenous cultural priorities are preserved and integrated into community-wide recovery and reconstruction efforts such as: funeral rites, memorial services, rituals, monuments and culture-specific coping behavior.

Post-traumatic stress responses

a) degree of social/cultural inequalities in mortality (especially among underprivileged or socially deprived individuals)?
b) magnitude of serious injury or illness from which recovery is unlikely?
c) amount of physical illness and/or injury associated with severe psychological reactions?
d) relative contagion (or epidemic) of fear and anxiety manifesting itself as treatment-seeking behavior
e) prevalence of depression, anxiety, suicidal behavior, psychosis, PTSD, alcoholism and substance abuse?
f) the longitudinal course of the above problems extended over the recovery and reconstruction period?

III. Risk Factors Among Children and Adolescents

Among children and adolescents, the major psychological problems occurring during recovery and reconstruction following war or other major catastrophes are: post-traumatic stress disorder (PTSD), depression, and anxiety disorders. It appears that if PTSD is to occur, it will do so within the first weeks or months following the event [10]. Depression, which may occur as a single problem or as a comorbid disorder along with PTSD, is often associated with loss of a loved one. Anxiety disorders are often associated with fears about safety and security. Among younger children it may be manifested as separation anxiety or school phobia whereas older children may exhibit phobic behavior and generalized anxiety disorder [11]. Although PTSD, depression and anxiety disorders observed during post-conflict recovery and reconstruction may be expressed at sub-diagnostic levels, the behavioral impact of such symptoms may be clinically important since they may significantly disrupt familial, interpersonal, social and educational function.

Given the fact that the above problems may not emerge until the post-traumatic recovery and reconstruction phase, usually months after the initial event(s), there is a potential opportunity to identify children and adolescents at greatest risk for such problems and to provide early psychosocial intervention that may avert chronic psychological problems. As noted by Silverman and LaGreca (2002) [11], there are four domains of predictor variables that may help identify children and adolescents at greatest risk for subsequent problems: aspects of traumatic exposure, preexisting characteristics of the child, characteristics of the recovery environment, and the child's psychological resources.

Aspects of traumatic exposure include perception of life threat, death of a loved one (especially if the death was violent and was witnessed by the child), parental post-traumatic distress, loss of possessions and disruption of daily routines (especially displacement from home, school and community), proximity to the event, physical injury, and the duration and intensity of life-threatening events. With regard to the latter, protracted and unpredictable violence, as with terrorism, is a major exacerbating factor.

Pre-existing characteristics are not well understood because the potential influence of age, gender, ethnicity, race, cultural and sociodemographic backgrounds have not been well studied. Pre-disaster anxiety, depression and ruminative coping styles appear to predict the later development of PTSD, depression and anxiety disorders [12]. Finally, there is evidence that children with pre-disaster academic difficulties, low

achievement and problems sustaining attention are at greater risk for post-traumatic problems [11].

Aspects of the recovery environment have been well studied. Perceived social support [13,14] appears to buffer children and adolescents against the adverse psychological impact of traumatic events. Receipt of substantial help, in additional to social support, also appears to be a protective factor [15]. Parental behavior and psychopathology also predict the quality of psychological adjustment with higher levels of parental symptoms predicting PTSD, emotional distress and behavioral difficulties among children and adolescents [16–18].

Psychological resources of children and adolescents (e.g., resilience) has not been well-studied in post-traumatic settings. In general, negative coping styles for dealing with stress (e.g., anger, blaming others) predict PTSD among children and adolescents [19,14]. As a result, Silvermann and LaGreca (2002) [11] suggest that efforts to encourage problem solving and adaptive coping skills may be useful post-traumatic interventions. Vernberg (1999) [20] has suggested that resilience may also be associated with average-or-greater intelligence, good communication skills, strong beliefs of self-efficacy, an internal locus of control and adaptive coping skills.

IV. Towards Promotion of the Psychosocial Well-Being of Children During Recovery and Reconstruction

Klingman (2002) [21] generalizing from his experience with Israeli children and adolescents has suggested a number of strategies to mobilize personal resources in order to promote better psychological outcomes. He proposes strategies that enhance both problem-focused coping (to improve personal safety) and emotion-focused coping (to minimize trauma-induced distress through avoidance, distancing, distraction, disengagement and minimization). Mobilizing energy in a positive capacity or for a cause (as in caring for the disabled) is also adaptive since it enhances a sense of control over one's destiny and generates hope for the future. Staying active in helpful behaviors, self-expression (through art), community/cooperative initiatives are all effective ways to promote resilience. Finally, helping children understand and "make sense" of their environment, fostering a sense of humor and promoting positive expectations about the future are methods of mobilizing psychological resources of children and adolescents that will all contribute to better outcomes during the recovery and reconstructive phase.

Omer and Alon (1994) [22] have proposed a continuity principle for children and adolescents that stipulates that "throughout all stages of the war cycle, intervention should be aimed at preserving and restoring continuities that had been disrupted as result of war. The more an intervention is built on the child's existing individual, familial, organization and communal (e.g., schools, neighborhood support services) strengths and resources, the more effective it will be in counteracting the disruptive effects of war" [21].

Implementation of the continuity principle has many components, all of which serve to help the child bridge important gaps in continuity. Restoring personal (historical) continuity includes restoration of basic needs and encouraging children to discuss and reframe personal traumatic events in a way that will integrate such events into a coherent personal narrative and generate positive expectations for the future. Interpersonal continuity involves restoration of social bonds, and establishing or enhancing interpersonal support with significant others. Functional continuity involves reestab-

lishment of pretraumatic home routines and duties. Finally, organizational continuity refers to efforts to rebuild the child's sense of order within a familiar neighborhood, if possible, or to provide a social context, such as a school setting, that will promote feelings of belonging and stability. It is clear, that schools provide one of the best arenas in which to achieve these goals, especially if the schools are working closely with community mental-health support services [21].

It should be evident from the previous discussion that "community-wide interventions are necessarily complex and require multimodal programs with extended community involvement because the effects of traumatization extend into many domains of a child's life, such as family, school, peers and health" [23]. There is growing consensus that the major components of trauma-specific intervention should include psychoeducation and a number of cognitive behavioral strategies such as anxiety management, trauma focus/exposure work, and confronting inaccurate and maladaptive cognitions [24]. Parallel treatment for parents and caregivers is also very important [25,23].

Ayalon (1993) [26] has developed a post-traumatic intervention for children that includes a variety of tools for enhancing coping skills in emotionally expressive, cognitive, and behavioral areas through participation in work groups designed to promote self-expression through play, creative expression and structured group therapy exercises.

After the Oklahoma City bombing, Gurwitch and Messenbaugh (2002) [23] drawing on the work of LaGreca et al. (1994) [19] developed a manualized treatment for children aged 5 to 12 that had many of the key elements discussed previously. It included educational material on basic safety skills during the immediate post-traumatic aftermath, psychoeducation, and treatment exercises to address symptoms and behavioral difficulties associated with trauma and loss. This intervention has been utilized in both school and more traditional mental health settings. It can be applied in individual, group, or classroom formats. Most importantly, parents and caregivers are also included [23].

The exciting school-based intervention developed by Mikus-Kos and associates is described elsewhere in this volume (see Chapter 2) as are other approaches utilized in Europe and the Middle East. We have reached a stage where there are many excellent conceptual and practical treatment options to consider. What is lacking at this time, however, is a solid body of rigorous research on these various approaches. This is the next step on which we must focus our energies. The goal, of course, is the development of the best evidence-based interventions to promote the psychosocial wellbeing of children during post-traumatic recovery and reconstruction.

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